FILED 2010 Mar-11 PM 03:16 U.S. DISTRICT COURT N.D. OF ALABAMA

## Exhibit 2

## UNITED STATES DISTRICT COURT NORTHERN DISTRICT OF ALABAMA SOUTHERN DIVISION

IN RE: CHANTIX (VARENICLINE) PRODUCTS LIABILITY LITIGATION		Master File MDL No. 2	e No.: 2:09-CV-2039-IPJ 2092
This Fact Sheet Relates To: MDL Case No.		Plaintiff:	(full name)
HIPAA COMPLIANT AUT OF INDIVIDUALLY II Person/Entity from Whom			
Records are Requested:	Provider N	Name ("Prov	idar")
	Tiovidel	vaine ( 110v.	idei )
	Address	City	y, State and Zip Code
Patient:			
	Patient Na	ime	
	Address		City, State and Zip Code
	Date of Bi	rth	Social Security Number
Information Authorized To B copies of my entire medical rec information, to include but not	ord and all	of my indivi	dually identifiable health

echocardiographic recordings, radiographic films, blood tests, MRI scans, MRA films, EEGs, EKGs, sonograms, arteriogram, pathology specimens, discharge summaries, photographs, videos, DVDs, emails, or other electronically stored information, data, or images, surgery consent forms, admission and discharge

records, operation records, doctor and nurses notes, progress notes, prescriptions, medical bills, medical reports and records, invoices, histories, diagnoses, narratives, correspondence, memoranda, and billing information, pharmacy records, prescription records including NDC numbers and drug information handouts and/or monographs. If the Provider is in possession of records from any other source, I authorize release of those records under this authorization.

This authorization includes records for treatment of psychological, psychiatric and emotional problems. It also includes, to the extent such records exist and are in the Provider's possession, employment records, workers' compensation records, disability records, social security records, and insurance records, including Medicare/Medicaid and other public assistance claims applications, statements, eligibility material, claims or claim disputes, resolutions and payments, medical records provided as evidence of services provided, and any other documents or things pertaining to services furnished under Title XVII of the Social Security Act or other forms of public assistance (federal, state, local, or other). This listing is not meant to be exclusive.

**Person to Whom Records are to be Disclosed ("Recipient")**: I authorize disclosure of the above specified information to the defendant in the above-captioned litigation, in which I am a plaintiff, and its authorized agent as set forth below:

Medical Research Consultants – Attn: RECORD RETRIEVAL

Name of Recipient or Recipient's Agent

Agent for Service of Record on Behalf of Defendant Pfizer Inc

Relationship to Recipient

10114 Sam Houston Parkway South, Suite 200, Houston, TX 77099

Address City, State and Zip Code

I further authorize disclosure to any counsel for Pfizer Inc in the above-captioned litigation, as well as any employees, agents, or independent contractors retained by such counsel and including but not limited to counsel for Pfizer's insurers. The Recipient has agreed to pay reasonable charges incurred by the Provider to supply copies of such records.

**Purpose of Disclosure**: I am requesting disclosure of these records in connection with the above-referenced litigation in which I am a plaintiff.

## **Acknowledgements:**

I understand that once information covered by this authorization has been disclosed, redisclosure of that information by the Recipient is possible, and the information may no longer be protected by federal or state law, including the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

I understand that information disclosed under this authorization could relate to, and I hereby authorize the disclosure of, information regarding treatment and testing for (please initial):

<del></del>	Drug or alcohol abuse
	Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), and other sexually transmitted diseases
	Sickle Cell Anemia
	Tuberculosis
	Genetic testing and counseling

I understand that my signing of this authorization is voluntary. Refusing to sign or revoking this authorization will not affect my health care treatment, enrollment in my health plan, or eligibility for payment and benefits under my health plan.

I further understand that, pursuant to applicable state law, I may have a right to receive a copy of this authorization as provided in 45 CFR 164.524.

**Term:** This authorization shall be valid through December 31, 2015 or the conclusion of my case, whichever occurs first. This authorization remains in full force and effect until such expiration, and further authorizes the Provider to release to the Recipient any additional records created or obtained by the Provider after the date hereof.

**Revocation**: I understand that I may revoke this authorization at any time by writing to the Provider at the Provider's above address, but my revocation will not apply to information that has already been released before the Provider receives notice of any revocation. Cancellation, revocation, or modification will only be valid once the Provider receives written notification of such cancellation, revocation or modification. A copy of said notification shall also be sent to the

Recipient identified above. I also understand that provision of this signed authorization is required by Order of the Court in the litigation to which this authorization pertains, and that such revocation, without good cause, may consequently lead to sanctions.

**Copies**: Any photostatic copy of this document shall have the same authority as the original, and may be substituted in its place.

Date:	
	Signature of Patient or Legal/Personal Representative
	Description of Representative's Authority to Act for Patient, if Applicable
FOR RECIPIENT'S US	GE ONLY –
Plaintiff's Lawyer(s) to	Receive Notices of Receipt of Requests and Records:
Lawyer's Name(s):	
Firm Name:	
Lawver's Email(s) (Requ	ired):